

30-000 Payment for Health Insurance Premiums

30-001 Introduction: The Nebraska Medical Assistance Program covers payment for health insurance premiums for individuals who are otherwise eligible for Medicaid when determined to be cost effective. This chapter contains the rules and regulations that apply to this benefit. Conditions of eligibility are addressed in Titles 468, 469, 470, 477, and 479.

30-001.01 Legal Basis: Sections 1905(a) and 1906 of the Social Security Act requires each state Medicaid program to provide this benefit.

30-001.02 Definitions: The following definitions apply to this benefit:

Cost Effectiveness: A determination, made by the Department, that the amount that the Nebraska Medical Assistance Program would pay for premiums, coinsurance, deductibles and other cost sharing obligations under a health plan, plus an amount for administrative costs is likely to be less than the amount paid for an equivalent set of Medicaid services.

Group Health Plan: Any plan of, or contributed to by, an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer's employees, former employees, or the families of employees or former employees. A group health plan must meet S. 5000(b)(1) of the Internal Revenue Code of 1986, and includes continuation coverage pursuant to Title XXII of the Public Health Services Act, S. 4980B of the Internal Revenue Code of 1986, or Title VI of the Employee Retirement Income Security Act of 1974.

Health Plan: Any health insurance plan that, in exchange for premiums paid, pays benefits for medical services. Excluding Medicare Part B premiums (see 471 NAC 1-007).

30-002 Covered Benefits: The Nebraska Medical Assistance Program covers payment of premiums for Medicaid-eligible enrollees in a cost effective health plan. NMAP also covers payment of all deductibles, co-insurance, and other cost sharing obligations under the health plan that are for services covered under NMAP.

30-002.01 Family Members: If a family member who is not eligible for Medicaid must be enrolled in the health plan to obtain coverage for the Medicaid-eligible client, NMAP covers payment only for the premiums; no other cost sharing expenses are covered. The family member may reside in a different household.

30-002.02 Services Covered by NMAP: A client's enrollment in a health plan does not change the client's eligibility for benefits under the Nebraska Medical Assistance Program. If services covered under NMAP are not covered by the health plan, the client may obtain those services from Medicaid-enrolled providers. Payment for those services is made according to the payment methodology currently in effect under NMAP.

If the client's health plan offers more services than covered under NMAP, NMAP does not pay for the deductibles, coinsurance, and other cost sharing obligations for non-covered services.

30-002.03 Medicare Enrollment: If the client is also eligible for Medicare Part B but is not enrolled in Medicare Part B, NMAP does not pay for the premiums or other cost sharing obligations to the health plan.

30-002.04 Cost Sharing Amounts Under NMAP: If the client is required to pay cost sharing amounts under NMAP, payment of the cost sharing amounts are not covered as a benefit under this chapter.

30-002.05 Available Resource: The health plan is considered an available third party resource.

30-003 Enrollment in a Group Health Plan: Group health plans usually limit an individual's enrollment period. If an individual who is already enrolled in a group health plan becomes Medicaid-eligible, NMAP buys into the group health plan as of the effective date of Medicaid eligibility.

30-003.01 Effective Date of Benefit: If a client is not eligible for coverage under a group health plan for a specified waiting period, NMAP buys into the group health plan as of the effective date of eligibility for the group health plan. Until the client is eligible to enroll or entitled to receive services under the group health plan, all Medicaid-covered services are covered and paid under the usual policies and procedures of NMAP.

30-003.02 Delayed Enrollment: If the availability for enrollment in the group health plan and eligibility for Medicaid do not coincide, the client/applicant shall apply for the group health plan (by completing the necessary forms if available). The enrollment application is held until open season and then the form is submitted.

The client/applicant is not eligible for Medicaid if s/he refuses to apply for enrollment in a group health plan. This ineligibility is effective until the next open season for group health plan enrollment.

30-004 Cost Effectiveness Determination: The Nebraska Medical Assistance Program (NMAP) determines the cost effectiveness of health plans using the following methodology:

1. Obtain information on the health plan available to the client. This information must include the effective date of the policy, exclusions to enrollment, the covered services under the policy, riders and exclusions of covered services, and premiums paid by the policy owners.
2. Using the Medicaid Management Information System (MMIS), obtain the total six-month estimated average Medicaid costs of persons like the applicant (age, sex, and category data). Adjust this amount for inflation.
3. Determine the amount of the total six-month Medicaid expenditures that are spent on the services covered by the individual policy, using the following categories: drugs, practitioner services (this includes physician services, durable medical equipment, other practitioners, etc.), inpatient hospital services, outpatient hospital services, and home health services.
4. Estimate the cost of coinsurance and deductibles up to the allowable amounts under the Nebraska Medical Assistance Program.
5. Determine the administrative cost to Medicaid for processing the health plan information by determining the average increase in cost per client for the six-month period.
6. Determine the cost to Medicaid with insurance by adding the following:
 - a. The administrative cost determined under item 5;
 - b. The coinsurance and deductible cost determined under item 4;
 - c. The premium cost (The premium cost is determined by applying a premium factor for the percentage of clients who would receive services compared to those eligible for Medicaid. This accounts for Nebraska's costs being based on "per client" data instead of "per eligible" data.); and
 - d. The cost of non-covered services (subtract item 3 from item 2);
7. Compare the cost to Medicaid with insurance (item 6) to the estimated average Medicaid costs (item 2). If the cost to Medicaid with insurance is less than the estimated average Medicaid costs, the health plan is cost effective. If the cost to Medicaid with insurance is equal to or greater than the estimated average Medicaid costs, the health plan is not cost effective.

30-004.01 Exceptional Medical Costs: If the client provides documentation of on-going medical costs that exceed the estimated average Medicaid costs (see item 2 in 471 NAC 30-004), NMAP may determine that the health plan is cost effective.

30-004.02 Spenddown Cases: NMAP has determined that payment of premiums for a health plan is not cost effective when the premium is used to meet a spenddown obligation under the medically needy program.

30-004.03 Non-Covered Benefits: NMAP has determined that payment of premiums for a health plan is not cost effective for the eligibility category of Aged.

NMAP does not pay premiums for health plans that are the court-ordered obligation of an absent parent.

30-005 Balance Billing: Medicaid pays only up to the amount allowed under the Nebraska Medical Assistance Program. For example, if a provider bills \$50 for a service and the insurer pays \$40, but the Medicaid allowable is \$37, Medicaid will not make up the \$10 difference between the billed amount and the insurance payment; NOR CAN THE PROVIDER BILL THE CLIENT. If the provider bills \$50 and the insurance pays \$37 and the Medicaid allowable is \$40, Medicaid can pay the difference, up to the Medicaid allowable - in this case, Medicaid pays \$3. THE PROVIDER CANNOT BILL THE CLIENT FOR THE DIFFERENCE BETWEEN THE MEDICAID PAYMENT AND THE BILLED AMOUNT.

30-006 Payment for Services: NMAP will pay the health insurance premium directly to the insurance carrier. If payment cannot be made directly to the carrier and the method of premium payment is payroll deduction, NMAP will arrange to pay the employer directly in lieu of the payroll deduction. If payment cannot be made directly to the carrier or employer, NMAP will reimburse the policyholder for the payroll deduction made for health insurance.

Some providers that participate in health plans may not be Medicaid participating providers. These providers will be encouraged to participate. Provider participation may be initiated through the submission of a bill for services. If providers refuse to bill Medicaid, NMAP may make payment directly to the client or financially responsible individual for the payment of coinsurance and deductible, up to the Medicaid allowable amount.